TOP STORY

WEDNESDAY, JANUARY 26, 2011

Setting up health insurance exchanges, states face big decisions

By Christine Vestal, Stateline Staff Writer

Governors have deep differences over national health care reform, but when it comes to so-called insurance exchanges — a centerpiece of the sprawling new federal law — nearly every state is moving ahead with implementation.

Health care in the states

Working under crushing deadlines, often with staffs thinned by layoffs, states have a massive job ahead of them: to essentially reorganize the entire health insurance industry within their boundaries. The goal of the exchanges is to make it easier for individuals and small businesses to shop for comparable coverage.

They're also intended to make it easier for low-income people to apply for Medicaid and help business owners and moderate-income individuals apply for federal tax credits. States must have simplified insurance offerings and a standardized application — plus a consumer-friendly online presentation — ready to pass muster with federal regulators by December 31, 2012. If they don't, the federal government will step in and run the exchanges for them.

Between now and the deadline, "states have a herculean task ahead of them with multiple decision points," says Anne Gauthier, senior analyst with the National Academy for State Health Policy. "There will be leaders and followers, but every state will want to create an exchange that reflects its own environment and culture. To do that, they need to get started now."

It's hard to find a state official, Democrat or Republican, who is opposed to the concept of an insurance exchange. Individuals and small groups are expected to get a better array of insurance choices; more people should buy coverage; and the resulting boost to competition will likely drive down skyrocketing premium costs. The federal government sweetened the deal by promising to foot the bill for setting up the exchanges, and gave states wide latitude to tailor their exchanges to meet their individual needs.

The exchange concept, in fact, has deep roots with Republican governors. In 2005, long before the Affordable Care Act was enacted, then-Governor Jon Huntsman, a Republican, called for an exchange to make sense of Utah's overly complicated insurance industry. Another Republican, Governor Mitt Romney, was at the helm in 2006 when Massachusetts launched historic legislation that became the model for the federal bill. And last September, it was California Republican Arnold Schwarzenegger who signed the first state law initiating a health insurance exchange under the federal act.

Many Republican governors who would prefer to see the federal health law repealed are nevertheless moving forward with an exchange. Indiana's Mitch Daniels is one of them. "There seems no alternative but to prepare for the possibility that Indiana will try to operate an exchange of some kind," he said a couple of weeks ago when he signed an executive order initiating the process.

Still, the power shift resulting from the Republicans' electoral wave may slow movement on exchanges in a few states. Wisconsin, for example, was seen as a leader in developing the IT component for its own brand of insurance exchange under Democratic Governor Jim Doyle. The state remains a contender for a federal grant to develop its technology so that other states can use it. For the moment, however, the project is in limbo as the state's new Republican governor, Scott Walker, decides how he wants to proceed.

Embracing exchanges

Other states have embraced the exchanges with unbridled enthusiasm. Maryland, for example, has been charging full speed ahead ever since the day the Affordable Care Act was signed, says the state's new health secretary, Joshua Sharfstein.

Sharfstein, who left his post as deputy commissioner of the U.S. Food and Drug Administration to take the job, says he did it because national health reform created "tremendous opportunity for progress at the state level." Less than two weeks into his new post, Sharfstein expects legislative hearings on the exchange and other reform issues will take up a big chunk of his time. "I don't expect it to slow down any time soon," he says.

So far, Maryland has created six study groups, held 35 public hearings and completed an economic analysis of the fiscal impact national health care reform is expected to have on the state. The final report, delivered to Democratic Governor Martin O'Malley on January 1, projects the state has the potential to cut the number of uninsured in half by providing insurance to some 350,000 people. Maryland expects to save more than $800 million over the ten years starting in 2014, in part because fewer people are expected to show up in the state's

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emergency rooms.

Legislation ahead

So far, only a handful of state legislatures have entered bills needed to set up state exchanges Maryland is not among them. But it's likely a bill will be ready for consideration there in the coming weeks.

According to Rachel Morgan, health care analyst with the National Conference of State Legislatures, some states will choose not to enact legislation this year. That's because the U.S. Department of Health and Human Services has said it will not provide details on what is known as the "essential benefits package" until September. By then, most legislatures will be adjourned for the year.

Under the Affordable Care Act, states will be required to provide Medicaid coverage for all adults up to 133 percent of poverty, starting in 2014. For most states, this represents a major Medicaid expansion.

The exchanges will cater to people who earn too much to qualify for Medicaid. For people above the new Medicaid income level but below 400 percent of the federal poverty line, state exchanges will offer federally defined benefit packages from private insurance companies. In addition, the Internal Revenue Service will provide a tax credit to help these consumers pay the premiums.

For some states, uncertainty about federal benefits requirements will deter progress, says Morgan. "No insurer is going to sign a contract with a state unless they know what they're required to offer," she says.

Although states can do a lot of the groundwork prior to enacting legislation -- and many have -- experts caution that states that fail to enact insurance exchange laws this year may fall behind and end up with fewer choices about how they want to tailor their insurance markets.

Striking a balance

To enact legislation, states have a number of decisions to make. First, they must decide whether the exchange will be governed by a state agency, a nonprofit or an independent commission. They must decide whether to create one exchange for individuals and a second for small businesses, or to combine them. And they must decide whether to provide marketing and administrative services for insurance companies in order to reduce their overhead costs, or let them advertise on their own.

Maryland, for example, has determined it will offer a single exchange that will be governed as an independent public entity. California set up a similar governing arrangement.

Numerous other decisions must be made along the way. But the biggest decision states will make is how tightly to regulate the insurance industry. In general, Republican-led states are expected to develop exchange models closer to Utah's, which simply serves as a clearinghouse for insurance companies. In contrast, Democratic governors are expected to gravitate to an exchange design closer to the one Massachusetts set up, allowing the state to exercise more control over the insurance industry and negotiate for the lowest premiums.

"The art of the exchange is striking a balance between getting carriers to participate and providing consumers with the best competitive choices," says health care policy analyst Linda Blumberg of The Urban Institute. "You won't get that balance if you let all carriers in and charge anything they want." Likewise, too many restrictions may force some insurance companies out of the exchange market.

Contact Christine Vestal at cvestal@stateline.org

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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Broadening the Scope of Nursing Practice

Julie A. Fairman, Ph.D., R.N., John W. Rowe, M.D., Susan Hassmiller, Ph.D., R.N., and Donna E. Shalala, Ph.D.

N Engl J Med 2011; 364:193-196 January 20, 2011

Comments open until January 26, 2011

Article

The Affordable Care Act promises to add 32 million Americans to the rolls of the insured at a time when there is a shortage of primary care providers. There is broad consensus that the next phase of reform must slow the growth of health care costs and improve value through payment reforms, including bundling of payments and payments for episodes of care. Some savings will derive from implementation of innovative models of care, such as accountable care organizations, medical homes, transitional care, and community-based care. We believe that if we are to bridge the gap in primary care and establish new approaches to care delivery, all health care providers must be permitted to practice to the fullest extent of their knowledge and competence. This will require establishing a standardized and broadened scope of practice for advanced-practice registered nurses — in particular, nurse practitioners — for all states.

Nurses' role in primary care has recently received substantial scrutiny, as demand for primary care has increased and nurse practitioners have gained traction with the public. Evidence from many studies indicates that primary care services, such as wellness and prevention services, diagnosis and management of many common uncomplicated acute illnesses, and management of chronic diseases such as diabetes can be provided by nurse practitioners at least as safely and effectively as by physicians.[1] After reviewing the issue, an Institute of Medicine (IOM) panel recently reiterated this conclusion and called for expansion of nurses' scope of practice in primary care.[2]

Some physicians' organizations argue that physicians' longer, more intensive training means that nurse practitioners cannot deliver primary care services that are as high-quality or safe as those of physicians. But physicians' additional training has not been shown to result in a measurable difference from that of nurse practitioners in the quality of basic primary care services.[1,2] We are not arguing that nurse practitioners are substitutes for these physicians, but rather that we should consider how primary care services can be more effectively provided to more people with the use of the full primary care workforce.

The critical factors limiting nurse practitioners' capacity to practice to the full extent of their education,

training, and competence are state-based regulatory barriers. States vary in terms of what they allow nurse practitioners to do, and this variance appears not to be correlated with performance on any measure of quality or safety. There are no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of physicians in less restrictive states has changed or deteriorated.

There is variation in several aspects of practice, including requirements for prescribing privileges, oversight and chart reviews, and the maximum "collaboration ratios" for nurse practitioners working with physicians. In some states, nurses cannot certify home health care visits or stays in skilled nursing facilities or hospice, order durable equipment, admit patients to hospitals without a physician's supervision or collaborative agreements, or prescribe medications without physician oversight. Nurses tend to move from more restrictive to less restrictive states, and from primary to specialist care, with a resulting loss of access to care for patients. Credentialing and payment are also linked to state regulations: more restrictive states are less likely than those allowing independent practice to credential nurse practitioners as primary care providers.[2,3]

Sixteen states plus the District of Columbia have already liberalized and standardized their scope-of-practice regulations and allow nurse practitioners to practice and prescribe independently (see map). Several other states are reconsidering their laws to allow independent practice and to adopt the Advance Practice Nurse (APRN) Model Act generated by the National Council of State Boards of Nursing. Under such laws, nurse practitioners may practice independently and be accountable "for recognizing limits of knowledge and experience, planning for the management of situations beyond [their] expertise; and for consulting with or referring patients to other health care providers as appropriate."[4]

Scope-of-Practice Regulations for Nurse Practitioners, According to State.

The trend toward easing restrictions is propelled by recent reports from several blue-ribbon panels. In addition to the IOM report, which specifically targets regulatory barriers, several policy briefs from other organizations, including the Macy Foundation, support broader scope-of-practice boundaries. One of the largest consumer groups, the AARP (formerly the American Association of Retired Persons), also supports an expanded role for nurse practitioners in primary care.

In addition to the data on the quality of care, the expected dramatic increase in demand for primary care services from Americans with insurance, and the impending shortage of primary care providers, there are several other reasons to relax state regulations. Effective implementation of new delivery models, such as medical homes and accountable care organizations, which would provide chronic disease management and transitional care, requires the establishment of interdisciplinary teams in which nurses provide a range of services, from case management to health and illness management. Such an expanded scope of practice and team-based approaches including nurse practitioners have been shown to improve quality and patient satisfaction and reduce costs at the Veterans Administration Health System, Geisinger Health System, and Kaiser Permanente.[2]

Reductions in cost associated with broadening nurse practitioners' scope of practice can be seen elsewhere as well. In U.S. retail clinics, where cost savings have been documented, nurse practitioners provide most of the care. But retail clinics have been slow to expand in states with more restrictive

scope-of-practice regulations. Research in Massachusetts shows that using nurse practitioners or physician assistants to their full capacity could save the state $4.2 billion to $8.4 billion over 10 years and that greater use of retail clinics staffed primarily by nurse practitioners could save an additional $6 billion.[3]

Since nurse practitioners' education is supported by federal and state funding, we are underutilizing a valuable government investment. Moreover, nurse practitioner training is the fastest and least expensive way to address the primary care shortage. Between 3 and 12 nurse practitioners can be educated for the price of educating 1 physician, and more quickly.[5]

Despite the robust rationale for broadening nurse practitioners' scope of practice, key medical organizations oppose the idea. The American Medical Association, the American Osteopathic Association, the American Academy of Pediatrics, and the American Academy of Family Physicians all support requiring direct supervision of nurse practitioners by physicians. As health care reform advances, implementation of payment reforms — including global or bundled team-based payments and medical home–based payments — may ease professional tensions and fears of substitution while enhancing support for an increased scope of nursing practice.

Legal considerations also seem to favor such a trend. The Federal Trade Commission recently evaluated proposed laws in three states and found several whose stringent requirements for physician supervision of nurses might be considered anticompetitive. The agency has also investigated proposed state policies that would protect professional interests rather than consumers.[2]

This is a critical time to support an expanded, standardized scope of practice for nurses. Economic forces, demographics, the gap between supply and demand, and the promised expansion of care necessitate changes in primary care delivery. A growing shortage of primary care providers seems to ensure that nurses will ultimately be required to practice to their fullest capacity. Fighting the expansion of nurse practitioners' scope of practice is no longer a defensible strategy. The challenge will be for all health care professionals to embrace these changes and come together to improve U.S. health care.

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The views expressed in this article are those of the authors and do not necessarily represent those of their institutions.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Comments (23)

Do you think the scope of nursing should be expanded?

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LISA REIS, MD | Physician | Disclosure: None
SAINT LOUIS MO
January 19, 2011

I practice in a state that currently has very restrictive policies regarding NPs and PAs. They must be supervised by physicians. However, in practice it seems MD PCPs provide only minimal oversight due to their overburdened schedules. These same MDs are legally responsible for all mistakes made by these NP/PAs. While I am in favor of allowing NP/PAs to practice independently I think they

Data by Profession and Location

should then bear the liability of their own mistakes. They also should undertake call responsibilities as MD providers do. I think there will be substantially less enthusiasm from NP/PAs who want an independent practice system when they are required to personally take the liability of misdiagnosis as well as the lifestyle required to take call on weekends,holidays etc.

SUZANNE PORTNOY | Student | Disclosure: None
ALBANY CA
December 21, 2010

It was interesting to read the perspective of several physician leaders on the recent IOM report recommending a broadening of nursing scope of practice. In their correspondence, the writers cite that 80% of ED patients expect to see a physician. Another ED statistic indicates that nearly 80% of patient visits to the ED are for either non-emergent or primary health care preventable problems - an ideal fit for the skill set of NPs and PAs. My question is this: Is it imperative to have seven years of post-graduate education and 10,000 hours of clinical experience to accurately diagnose and safely treat today's common afflictions: diabetes, heart disease, COPD, obesity, to name a few?

The IOM is arguing that NPs are well trained to handle urgent and chronic health conditions. Many states already recognize the strength of NP training and for decades have allowed them to work to the full extent of their education. In fact, everyday in this country NPs and PAs assess and treat a wide variety of maladies. When necessary they collaborate and refer patients to physicians. NPs do not need physician supervision to practice safely and provide quality care.

TAYLOR WRIGHT | Student | Disclosure: None
CORDOVA TN
December 19, 2010

It is exactly these sorts of comparison statements (i.e. that NPs/PAs/etc. can provide equal quality and efficacy of care) that give almost all medical students pause when looking to primary care. If indeed they can, then why ought I go into those fields as a physician? Would it not simply be a waste of the training I am given, to go into a field in which the patients could be treated just as effectively by practitioners who take less time and money to train?

In reality, I do believe that properly trained physicians are equipped to provide high quality and broad-scope care, acting as a primary provider for 90% of a patient's needs. And the idea of primary care appeals to me very much for that reason; the breadth of practice and the continuous care for patients from all stages of life. However, I also live in the real world, and the fact is I don't think people want that anymore. Rather, they want whoever is quicker and cheaper; whoever fills the needs of the moment, the ongoing relationship being irrelevant.

In the end I have to compete to sell my skills in a marketplace, and there's no sense trying to sell something no one is buying.

PHILIP MILLER, MD | Physician | Disclosure: None
PORTLAND OR
December 18, 2010

We're all on a continuum with our knowledge, training, and experience. Knowing our limits and when to seek help is more important than a degree. Let's elevate the conversation. Cooperation, not competition.

ANITA MALHOTRA, MD | Physician | Disclosure: None
December 18, 2010

I flatly disagree that the scope of nursing practice should be broadened. While I do think they add to the team and have a role in clinical practice, in no way should they be independent. It is not possible to equate nursing school and medical school. Nor is it possible to equate years of residency training with a few months of clinical rotations. The outcomes "studies" were not sufficiently powered to detect any real difference, nor was there any control of variables. Outcomes studies are extremely difficult to do in these cases and whether they are even ethical or not is questionable.

I spent a year as a specialty consultant physician. The emergency department had a side that was staffed by NPs and a side that was staffed by MDs. I received over twice the number of consultations from the NP side, most of which I would say would have been handled by any competent emergency

department or internal medicine physician. Is this cost effective care? A consultant fee can be very expensive, therefore driving up the cost of the encounter. Lack of training and education IS ultimately going to prove to be expensive.

Kithsiri Senanayake, MBBS | Physician - Surgery, General | Disclosure: None
KANDY Sri Lanka
December 18, 2010

The nursing is a noble profession. Nurse's knowledge, attitudes and dedication are very important for the care of ill. The nursing and the medicine are two different professions. The ward 'Nursing' itself implies their duty. A mother nurse her child, she feeds her child. She monitors the Childs growth and detects any minor change in her Childs behaviour. But she should never try to do the duties of the father, which she may do but with sub optimally or may even do the wrong.

Nurses should do the nursing. They should try to expand the horizons of their profession. Expanding the scope is not the encroaching of other profession. The person who diagnoses and prescribes is a physician. If a nurse really wants to be a physician she should enter into medical college and get through the nescecery exam and intern. There shouldn't be shortcuts to be a competent person who handles the human lives. We are very fortunate that there are no practising nurses in my country. We have enough qualified doctors and our health cares indices are not second to any develop country.

Jane Gresser | Other | Disclosure: None
New Berlin WI
December 17, 2010

Physician Assistants practice medicine under physician supervision, and are limited to practicing under the specialty of their supervising MD. Their role is to extend the reach of the physician; which is why they are often referred to as "Physician Extenders." The PA profession promotes the MD-PA team, and not to independently practice without the MD. With a shared mission between the MD and PA, more people can be served. It is the MD that expands the role of the PA with continued training under their direction. This type of collaboration should be expanded as health care looks to provide services to more people.

DR HENRY STEVENS | Other | Disclosure: None
COLORADO SPRINGS CO
December 17, 2010

I am recovering from heart surgery. The RN and support staff of the cardiac rehabilitation unit and my pharmacist have contributed significantly to my recovery.

From my experience, RNs and NPs have the interest and time to provide the individual care that is needed in preventative care and during recovery from surgery.

Paul Colopy | Physician | Disclosure: None
December 17, 2010

A increasing need exists for greater and less expensive access to all areas of health care in this country. Whether this will be adequately addressed by independent nurse practitioners and physician assistants depends on whether or not they provide a level of care quality equal to physicians. The pragmatic bottom line question is whether or not degrees such as M.D., D.O., Ph.D. in Nursing, Ph.D. in Physical Therapy, R.N. really have any meaningful significance. Does achieving each of them, for example, certify a proportionate baseline level of intelligence, work ethic and knowledge? Whether in fact the far greater intensity and duration of physician medical education translates to superior patient care will soon enough become apparent when those without such background have widespread independent practice. In May of this year, it was reported that nurse practitioner liability claims are already increasing at a rate of 2.3% per year. If the purpose of nonphysicians providing independent care is to increase availability and decrease costs, then increased error rates and defensive medicine testing may well offset all the good intentions; but only if physician extra training isn't a pointless waste. It is also equally probable that the promise to practice in under-served areas will soon migrate away into more remunerative areas instead. Why discriminate against the poor and geographically isolated? A perhaps laudable effect of such expanded scope will be to absolutely eliminate any motivation to suffer through the extra worthless costs and rigors inherent in becoming a primary care physician. Why in the world would an intelligent student choose to take on all that extra outlay and all that extra stress and all those extra years if at the end of it they have nothing to offer the public superior to those providers with less of all three. It would seem that the smart choice of an aspirant interested in primary care would be avoid all that. With the implied emptiness of the inherent value of degrees, why with little extra effort can't LPNs be equal to RNs, RNs equal to Nurse Doctorates, Nurse Doctorates to physicians, etc. P.T assistants can call themselves physical therapists, why not? The logic is the same. Those who wish to expand upward by political fiat, are vulnerable to the same from below. No offense to NPs, PAs intended.

Early in the nineteenth and twentieth centuries, this trend of degree dilution also gradually developed, but because of all the resulting problems, was finally corrected (The Flexner Report). Medical school may end up being reserved for those who manage the acutely ill or for difficult specialties combined with medical research. I haven't seen that nonphysicians are clamoring to also independently manage extremely ill people in the hospital, as so many physicians do currently. The intended effect is to skim the cream and not for the gravely ill, whereas medical students are meticulously trained to handle the entire range. Perhaps the admittedly greater admission difficulty and rigor of medical school is not necessary for outpatient care. It may soon be possible that with EMRs, someone with reassuring people skills, a professional demeanor, and a computer algorithm can provide superior care without having gone through the trouble of any sort of post high school education. Voila!! A GED is an M.D.!!

Paul M. Colopy, M.D.

JAMES BERNHEIMER, MD | Physician | Disclosure: None
HANOVER MD
December 16, 2010

Who bears the liability for a missed diagnosis? The nurse practitioner or the supervising physician?

JEAN STANLEY, MSN FNP | Other | Disclosure: None Elizabeth
FOUNTAIN HILLS AZ
December 16, 2010

I work in Arizona, one of the most unrestricted states in the nation in regards to NP practice. There are miles and miles of areas that no physician will go to practice that NP's and PA's fill. For years physicians have constantly have indicated that we are not safe to practice independently. I have seen multiple times where if a physician would work WITH the NP/PA rather than against the patient would receive a well rounded care experience. We all know our limitations, when to look to a specialist physician and YES even a specialist NP. I refer anyone that asks me to a practice that is either independent or even in collaboration with a physician that has an NP. The patient (including family members) are extremely happy and PREFER to see the NP/PA. So instead of throwing up the fence, throw down the gauntlet and work alongside, not against and for heavens sake please change the language that currently exists where in Arizona we can write for a narcotic but cannot write for home health. We can sign a death certificate but cannot certify someone for skilled for hospice when that patient may be the only provider they have seen and do not know who the physician is.

Tim Elwell | Other | Disclosure: None
December 16, 2010

As the business manager for a solo NP practice in NY, the issue of mandated collaboration amounts to no more than a 'restraint of trade' as it interferes with free competition in providing healthcare services and needs to be eliminated. It places an unusual burden on the NP that creates a real impediment to doing business. As licensed professionals, NPs collaborate with physicians anyway. To impose mandatory legal collaboration raises the bar on their business that is unfair and NPs in those states in which such a requirement exists should be encouraged to file a class action suit against the offending state or minimally pursue legislative remedies. As the NEJM article confirms, 16 states and the District of Columbia have already come to that conclusion and their patient outcomes are no worse than the states that have more restrictive statues. Study after study has concluded that the care delivered by an NP within a defined scope of practice is as good as if not better than those services provided by their physician colleagues. And the services are provided at lower risk and lower cost. For instance, the malpractice insurance our practice pays for our NP is about a tenth the cost of her physician colleagues. This lower cost is not because the insurance company likes the NP more or is now a benevolent business; it's because the claims for NPs are much lower than for a physician. NPs understand their "scope of practice" and refer out in accordance with that agreement – thus lowering their risk – as attested to in a lower malpractice premium. Lastly, Medicare currently reimburses NPs at 85% the rate of a physician which coincidentally has been picked up by many private insurers (which increases their margins and their shareholder value.) Extending this reimbursement in the current fee-for-service payment environment by encouraging more NPs to go into private practice would dramatically reduce healthcare costs. However, at a time when medical home and ACOs are coming into their own and incentives are beginning to be driven based on outcomes, NP deserve a seat at this table and should be reimbursed based on their performance (which would suggest reimbursement

equal to or more than their physician counterparts).

CELINE ARANJO, MD | Physician | Disclosure: None
SYDNEY Australia
December 16, 2010

Nurses and Physician Assistants do have an existing role in practices and this is a good thing. However, to broaden this scope because of 'shortage of physicians' is not acceptable to me, because of the main reason that physician training has been far more intensive and relevant to patients' health and well-being than that of NPs and APs, and because of this given reason, costs to the patients are going to be increased not only monetary, but detrimental to their health and well-being as well.

BARTON NASSBERG, MD | Physician | Disclosure: None
FREEHOLD NJ
December 16, 2010

If the AMA had not been restricting med school slots, perhaps we would have enough MD's.

If we're going with "medical care lite", why neglect homeopaths, naturepaths, aroma therapists, shamans and faith healers? They can all lay claim to a piece of the pie.

Randy Kuiper | Other | Disclosure: None
December 16, 2010

I feel pharmacists represent another important avenue to increase access to primary care services. In fact, I would argue that pharmacists are already providing a great deal of primary care in the United States today. Patients routinely seek out pharmacists for advice and recommendations related to common ailments they experience. Pharmacists often recommend nonprescription drug treatment. However, in many cases pharmacists also advise patients to seek further assessment from their physician.

Pharmacists are among the most accessible health care providers. Pharmacist training includes physical assessment and disease state management of many common chronic illnesses. Pharmacists in many states are now providing vaccinations. Expanding the scope of pharmacist practice should also be considered in the discussion to increase patient access to primary care services.

Randy Kuiper, PharmD

LINDA PEARSON | Other | Disclosure: None
LAKEWOOD CO
December 16, 2010

As author of state-by-state legislative summary for Nurse Practitioners for past 23 years (available at www.webnponline.com) I have closely followed the legislative progress toward removing practice barriers for NPs. I applaud statements in this NEJM "Perspective" AND the Editorial by Dr Susman in the most recent Journal of Family Practice. Both validate the safe care provided by NPs, and indicate that we have (at last) reached a 'time to collaborate' rather than 'compete' with MDs. When I look at those states I rank as an "F" for legislatively sanctioned patient access to NPs (i.e. Alabama, Florida, Georgia, Michigan, Missouri, North Carolina, South Carolina) AND those I rank as an "D" (i.e. Arkansas, Illinois, Indiana, Louisiana, Massachusetts, Nebraska, South Dakota, Texas, Virginia) I do NOT see citizens with a healthy status or safer care (delivered by MDs); instead there is solely a restraint of trade desire by organized medicine to protect their turf. BUT, I am thrilled with the desire to promote patient care access and the professionalism of many physicians within the other states (that rank "A", "B" & "C").

CLINTON BLUMER | Student | Disclosure: None
SIGNAL MOUNTAIN TN
December 16, 2010

I read both of your articles and found them both interesting. Yes, I would like to read more of your articles on Nursing and yes, I would like to see the scope of nursing practice expanded. I am a retired Advance Practice Nurse and I practiced Anesthesia for 40 years. A good part of my practice was independent where I practiced alone with no supervision. The last time I checked, there are 29 states within the U.S.A where CRNA's can practice autonomously. I also practiced Pain Management for 11 years, but this was under the supervision of an M.D. The American Nurses Association, et al. is primarily responsible for the shortage of nurses, and especially nurse educators. They will not allow me, for example, who has a B.S. in Health Education, a M.A. in Education, and now a Ph.D candidate to teach in a school of nursing because none of my degrees are in nursing. I ask you, do all instructors in medical schools have an M.D. degree? Of course they don't. Some are chemists, some anatomist, etc. The Nursing Profession has put themselves so high up on the ivory tower that they do not know how to get down, and if they did, they would refuse to do so. LPN's are taking over Nursing.

RANDY WEXLER, MD | Physician | Disclosure: None
GAHANNA OH
December 16, 2010

Physicians agree that nurses are an integral part of the team. However, the assertion that outcomes exist to support independent nurse practice and that nursing care is as safe and effective as that delivered by physicans are not as clear as stated by the authors. Specifically, the authors reference the Cochrane Review from 2004. What they fail to mention are the caveats expressed by this review. Although Nurse Practitioners received high scores for satisfaction, studies demonstrating outcomes were limited and had "methodological problems" especially a lack of statistical power. More than half occurred prior to 1980, and only four were recent (the latest of which was in 2001). The reviewers

concluded that although the findings "suggested" that nurses may produce care of the same quality as primary care physicians, that their conclusion should be "viewed with caution given that only one study was powered to assess equivalence of care, many studies had methodological limitations, and patient follow-up was generally 12 months or less". What is clear and data driven are the benefits of primary care physicans as demonstrated by the work of Barbara Starfield and others.

LAWRENCE REYNOLDS, MD | Physician | Disclosure: None
FLINT MI
December 16, 2010

I have always valued the abilities of nurse practitioners and their contributions to primary care.My concern is that non- board certified doctors are being excluded from some managed care contracts while NPs and PAs are permitted to see patients .It is a matter of time before MOC will become a criteria to limit practice or staff privileges. Nine percent of all pediatricians have allowed their certification to lapse.For the 50-60 year old cohorts, the lapse percentage is between 20-22%. Is the average trained ,experienced and licensed physician less competent than our nursing colleagues ? Is there any evidence to support that MOC improves quality of care ? Does this also mean that the other quality initiatives , including guidelines ,CME , and CQI projects are less effective ? Additionally , if the MOC process is so effective , why must the physician be board certified to take the exam ? The current direction of policies will exclude those who practice in underserved communities or the military and cause senior physicians to retire sooner.There are unintended consequences on the primary care workforce.There are not enough NPs to fill the gap. .

jeffrey hazzard | Other | Disclosure: None
December 16, 2010

The turf war, waged more savagely in my home state of Florida than about anywhere else, is rediculous and not becoming to our parent professional organizations. We should emancipate us nurse practitioners and you physicians should not be afraid of it. In fact, it IS HAPPENING...the organized medicine decision is going to be whether to climb aboard as the train leaves the station or to be left on the platform (literally and figuratively) of the past. There are more than enough patients to go around. Any problems which arise will be evident and corrected, I'm confident. We will all be able to get on with the most efficient model of patient care once these issues are past us. The titular protection of the demain of health care as a singular province of physicians is going to end, but the opportunity for, necessity of, and practice by physicians will not change appreciably. Thanks for reading.

Ellen Richter | Other | Disclosure: None
December 16, 2010

I appreciate the publicity your medical journal has given to the promotion of the nursing profession this month! As a practicing bedside nurse with an advanced nursing degree, I am so proud that the IOM has publicly announced its recognition of the importance of the expanding role of nurses. We, as nurses, are proudly committed to raising the bar on our minimal standard for nursing education. We

also understand that to expand our scope of independent practice, we need to enrich our professional educational growth beyond the minimum college degree. We, as nurses, understand that advanced knowledge promotes a greater understanding of the science of human behavior. We are excited to see that, because of the growing health care crisis, we are able to provide some solutions by having nursing professionals deliver advanced practice nursing care to those patients in need of medical care. We are not asking other health care professions for permission to raise our bar, but we do need support & backing as we move toward achieving our professional goals. And, finally, the patients & their families are the true focus of all of our health care goals, no matter who we are. Happy holidays!

ANTONIO AUGUSTO FIDALGO-NETO | Other | Disclosure: None
NITERI Brazil
December 15, 2010

While the nursing in USA should be expanded, here in Brazil the nursing care must be shortened. Last week an auxiliar nurse gave vaselin in place of saline solution in a child that died. Many tragedies like this happen daily in Brazil. We can see a poor educational formation in whole health area in Brazil. The expansionist policy of colleges made in Brazil resulted in a increase of number of students and instituitions with no worry about quality of education.

DAVID MITTMAN, PA | Other | Disclosure: None
LIVINGSTON NJ
December 15, 2010

There is no doubt that NPs can provide primary care and do it well.
I would make two additional points. One is don't forget PAs. We also provide high quality primary care and also do it in satellite and remote places. We also are excellent clinicians and provide another profession more than willing to practice our profession to alleviate the primary care shortage problem..
The second point is one that most in organized medicine is missing. You do not have to have a physicians education to practice good primary care. To keep looking at NP or PA education and saying it does not equal that of physicians is a moot point. It does not have to, it has to be good at training clinicians to practice primary care. After 45 years, PAs and NPs have shown they can do that.
We need to work together not against each other. Neither NPs, PAs or physicians are going away.
Dave

Newest Oldest

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Letters

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

The States' Next Challenge — Securing Primary Care for Expanded Medicaid Populations

Leighton Ku, Ph.D., M.P.H., Karen Jones, M.S., Peter Shin, Ph.D., M.P.H., Brian Bruen, M.S., and Katherine Hayes, J.D.

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Article

In the coming years, the United States must address both an expansion of Medicaid coverage and an expected shortage of primary care physicians.[1] Under the Patient Protection and Affordable Care Act (ACA), the Medicaid eligibility threshold for nonelderly adults will rise to 133% of the federal poverty level (about $30,000 for a family of four) in 2014. States with restrictive Medicaid eligibility requirements and high rates of uninsured residents will expand coverage substantially, while programs in states with higher current Medicaid eligibility thresholds and fewer uninsured residents will grow less. However, since many of the states with the largest anticipated Medicaid expansions are also the ones that have less primary care capacity, they could face surging demand from the newly insured without having sufficient primary care resources available. These gaps could affect access to care not only for newly eligible Medicaid beneficiaries but also for others who depend on a state's existing supply of clinicians.

To examine the potential gaps between demand and capacity, we computed measures of potential Medicaid expansion and current primary care capacity in each state and the District of Columbia. To determine the size of each state's Medicaid expansion, we calculated the number of nonelderly adults who, according to census data for 2008–2009, are uninsured and eligible under the 2014 Medicaid criteria and who, according to estimates from the Urban Institute, might enroll in Medicaid under the ACA.[2] To determine each state's primary care capacity, we calculated the number of primary care providers (physicians in general, family, or internal medicine, pediatrics, or obstetrics–gynecology as of late 2008, plus adjusted estimates for nurse practitioners and physician assistants) and the number of patients who were served at federally qualified health centers (FQHCs) in 2009. We focused on FQHCs because a majority of patients at such centers are Medicaid beneficiaries or are uninsured. (Data and estimation processes are described in the Supplementary Appendix, available with the full text of this article at NEJM.org.)

A composite "Medicaid expansion index" and a "primary care capacity index" were computed for each state; all indexes were standardized for state population and set to average 100 across the states. We then computed what we called an access-challenge index, by dividing the Medicaid expansion index by the primary care capacity index and set this index to average 100 as well. States with access-challenge scores exceeding 100 have higher-than-average Medicaid expansions relative to their current primary care capacity, so they will face a larger challenge.

Eight states — Oklahoma, Georgia, Texas, Louisiana, Arkansas, Nevada, North Carolina, and Kentucky — face the greatest

challenges (see Table). These states are expected to have large Medicaid expansions yet now have weak primary care capacity. In the absence of additional efforts, the demand for care by newly insured patients could outstrip the supply of primary care providers in these states. Seventeen other states with access-challenge scores above 100, most of which are in the South or the Midwest, could also face problems. Massachusetts, Vermont, the District of Columbia, Maine, New York, Rhode Island, and Connecticut have scores below 50, indicating that they have greater capacity relative to the size of their expansions.

Access-Challenge Index Scores for States, According to Rank.

Our analysis underscores the fact that the Medicaid expansions — a crucial dimension of health care reform — will affect states' primary care systems in varying ways. Of course, actual circumstances could be more complicated. Access to care is determined in local service areas, not at the state level. Access problems could be more severe in rural or inner-city areas than in suburban communities, for example. Moreover, even states with low access-challenge scores could face difficulties if, for example, many physicians will not accept Medicaid patients even after Medicaid's fee levels for primary care are increased. Although we focused on primary care, patients also need specialty care services, and states could face problems with access at the specialty and subspecialty levels. And we cannot be certain of the actual size of each state's Medicaid expansion nor of the future number of primary care providers; our numbers are estimates extrapolated from current data.

All states and communities need to consider the potential effects of expansions of both Medicaid and private insurance coverage through the new health insurance exchanges. Newly insured populations will demand more primary care services. If the new demand exceeds the supply of care, the result could be increased waiting times and access barriers. This pressure on services could affect not only Medicaid patients but also privately insured and Medicare patients, since each community is served by a limited pool of providers. Patients who cannot get timely primary care in health centers or physicians' offices may spill over into more expensive emergency rooms or experience delays that result in otherwise avoidable hospitalizations for conditions that could be treated in ambulatory care settings.

We found that high rates of uninsured residents were correlated with lower primary care capacity. One reason that some states, such as Oklahoma, Georgia, and Texas, have so few primary care physicians may be that high rates of uninsured residents and poverty make it harder for them to attract and retain practitioners. In the long run, expanded insurance coverage should support more primary care practices in undersupplied areas and eventually help to level out disparities in primary care capacity. But the insurance expansions do not begin until 2014, and it could take considerable time for capacity to balance out on its own.

The ACA makes important new investments in FQHCs and the National Health Service Corps, and the capacity of FQHCs is expected to double in the coming years.[3] The federal government could implement a ramp-up strategy focused on the most affected states and communities. The ACA provides federal funding for increasing Medicaid's fees for primary care to 100% of Medicare rates in 2013 and 2014, which should make Medicaid more attractive to primary care practitioners. The law also calls for strengthening plans for development of the health care workforce at both national and state levels.

The interstate differences in Medicaid expansions and primary care capacity underscore the importance of state-specific plans to strengthen that capacity. Of course, these plans should include efforts to train, attract, and retain primary care physicians. In addition, initiatives to train and deploy more nurse practitioners and physician assistants may work more quickly and be less expensive in the short run. Many of the highly challenged states have a lower-than-average ratio of advanced practice clinicians to primary care physicians, so are less able to utilize efficient team-based care. Many also have limiting scope-of-practice laws that restrict nonphysician clinicians in places where their skills are most needed, as the Institute of Medicine has recently noted. Finally, state Medicaid agencies should carefully monitor the ratio of clinicians to enrollees, both in managed-care plans and fee-for-service programs, to ensure that primary care capacity is adequate to serve their beneficiaries.

The ACA takes a fundamental first step toward improving access to care by expanding insurance coverage. It also bolsters federal resources to help meet the heightened demand for health care services. Addressing the goals of health care reform will take a combined federal, state, and local strategy involving resource deployment and actions designed to expand the available short-term and long-term supply of well-trained primary care professionals who are ready and willing to serve the newly insured. Ensuring access to care will depend on our ability to achieve smart growth in both insurance coverage and primary care capacity.

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Tables provided by the authors are available with the full text of this article at NEJM.org.

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